



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ANESTHESIA ALLIANCE OF DALLAS PA
PO BOX 202918
DALLAS TX 75320-2918

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-0356-01

MFDR Date Received

JULY 28, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has denied payment of Codes 99195 59 and 43753 59 stating that the 'benefit for this service is included in the payment/allowance for another service/procedure'...These codes have been denied in error, and are to be reimbursed as a separate procedures."

Amount in Dispute: \$143.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "it is the carrier's position that the bill was paid correctly. The provider's use of modifier 59 is incorrect. Supplies are always inclusive per NCCI guidelines with the anesthesia procedures."

Response Submitted by: Chartis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2011	CPT Code 99195-59	\$110.27	\$0.00
	CPT Code 43753-59	\$33.27	\$0.00
		\$143.54	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, 33 TexReg 626, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits
 - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - VA13-This procedure is included in another procedure performed on this date.

Issues

1. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

According to the explanation of benefits, the respondent denied reimbursement for CPT code 99195-59 and 43753-59 based upon reason codes "97, and VA13."

The requestor states in the position summary that "These codes have been denied in error, and are to be reimbursed as a separate procedures."

The requestor also noted on the request for reconsideration that "Both codes were billed with modifier 59 which indicates a separate billable procedure and is to be reimbursed separately from other procedures billed for this date of service."

CPT code 99195 is defined as "Phlebotomy, therapeutic (separate procedure)," and CPT code 43753 is defined as "Gastric intubation and aspiration(s) therapeutic, necessitating physician's skill (eg, for gastrointestinal hemorrhage), including lavage if performed."

The National Correct Coding Initiative (NCCI) Policy Manual states that "Blood sample procurement through existing lines or requiring venipuncture or arterial puncture; and 43753, 43754, 43755 (Esophageal, gastric intubation)" are included in the anesthesia service .

A review of the Anesthesia record indicates "Bld Draw from T&C 1037-1040." This documentation does not support a separate service.

The submitted documentation does not support billing of CPT code 43753 as a separate surgical procedure.

Per the NCCI Polity Manual, these services are inclusive to the anesthesia services.

Furthermore, the 2011 Trailblazer Anesthesia Manual states "Anesthesia time begins when the anesthesiologist starts to prepare the patient for the procedure. Normally, this service takes place in the operating room, but in some cases, preparation may begin in another location (i.e., holding area). Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption."

A review of the Anesthesia record indicates that the anesthesia started at 0655 and ended at 1112, for a total of 257 minutes. The Division finds that on the bill the requestor billed 257 minutes. The documentation does not support an interruption in anesthesia time for CPT code 99195 and 43753; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	06/26/2013 _____ Date
--------------------	---	-----------------------------

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.